Berrien Mental Health Authority
REPORT OF DEATH / CLINICAL SUMMARY

DATE OF REPORT:

RECIPIENT INFORMATION

Completed by Case Manager, Primary Clinician or Clinical Assistants

Recipient Name:	Case Number:	Medicaid ID Number:
Address:		Living Situation: (do they live in a licensed home, with family, a general AFC, be specific)
Date you were notified of death:		How were you notified about the death: (phone call, email, text, explain here)
Date of Death: (must be accurate)		Place of Death: (home, hospital, community, where were they when they died, be specific, this is needed to request the death certificate, autopsy and police reports as applicable)
Primary Clinician Name:		Person Completing Form if different from Primary Clinician: (Entering your name is also your signature)

TREATMENT INFORMATION

Completed by Recipient Rights Department

Last hospitalized in Psychiatric Hospital:	Last hospitalized (in State Psychiatric (KPH), DD Center, Child Caring Institution, and location if within 1 year from date of death): Date: Location:
Was the Recipient receiving Hospice Care:	Was the Recipient in a medical hospital prior to or at the time of death:
Can insert a screen shot of Diagnosis Code and Description	
Primary ICD 10 Diagnosis Code:	Description:
Secondary ICD 10 Diagnosis Code:	Description:
ICD 10 Diagnosis Code:	Description:
ICD 10 Diagnosis Code:	Description:
ICD 10 Diagnosis Code:	Description:

Provide a summary of the conditions the consumer is receiving Mental Health Services for including recent changes. (**include what authorized services were provided within **last one year**, Medications, Therapy, Targeted Case Management, Comprehensive Case Management, ACT, Supports Coordination, HAB Waiver, CLS/frequency & duration, Specialized Residential – Type A or B, etc… this is not an exhaustive list*):
Summary of Physical Health Status including recent changes: (as found in progress notes or documents in IRIS)
Medications prescribed by Agency Physician within last 30 days: (as found in IRIS)
Cause of Death as reported to -or- as identified in death certificate if available when completing this form: *(*if suicide include method, if accidental include type of accident and how it occurred, if natural give specific cause, was it expected or unexpected):*

RECIPIENT DEATH FOLLOW UP

Death Certificate	Date requested:
Has an autopsy been ordered?	If yes, date requested:
Is there a Police Report?	If yes, date requested:

Signature: Date:

Completed form is submitted to the Records Department